Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AHMED KHALIFA MD

Respondent Name
TASB RISK MGMT FUND

MFDR Tracking Number
M4-11-1703-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
JANUARY 28, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier refuses to pay total amount due even after a request for reconsideration was sent."

Amount in Dispute per Updated Table: $86.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The respondent did not submit a position summary in the dispute packet.

Response Submitted By: TASB

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 30, 2010	CPT Code 99201 –New Patient Office Visit	$3.22	$3.04
	CPT Code 95861 – Needle EMG	$6.47	$5.94
	CPT Code 95900(X4) – Nerve Conduction Study	$0.00	$0.00
	CPT Code 95904(X4) – Nerve Conduction Study	$51.88	$35.72
	HCPCS Code A4556 - Electrodes	$25.00	$0.00
TOTAL		$86.57	$44.70

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, *33 Texas Register 364*, sets the reimbursement guidelines for the disputed service.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 150-Payment adjusted because the payer deems the information submitted does not support his level of service. Only right shoulder is compensable. Code used is for testing of 2 extremities.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - W3-06/29/10-Original audit stands, no further payment due at this time. Additional payment made on appeal/reconsideration.
   - 97-Payment is included in the allowance for another service/procedure. Comparison studies are not reimbursable. Left Median and left Ulnar. Only right shoulder compensable.
   - 97-Payment is included in the allowance for another service/procedure. This service is global, integral, and/or a component of primary procedure billed.
   - 18-Duplicate claim/service. Previously processed and denied with EOMB#1935846.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment. Charge reimbursed previously with EOMB#1935846, $339.23, CK#5306637 posted 6/09/10.

Issues

1. Is the value of HCPCS code A4556 included in the value of another service rendered on the disputed date?
2. Is the requestor entitled to additional reimbursement for CPT codes 99201, 95861, and 95904?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for HCPCS Code A4556 based upon reason code "97."

   HCPCS Code A4556 is defined as "Electrodes (e.g., apnea monitor), per pair."

   28 Texas Administrative Code §134.203(a)(5), states "'Medicare payment policies' when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   Per Medicare policy, if HCPCS codes A4556 is incidental to the physician service, it is not separately payable. A review of the submitted documentation does not support a separate service. As a result, reimbursement is not recommended.

2. A review of the submitted explanation of benefits, finds that the respondent did not maintain its denial/reduction of payment for CPT codes 99201, 95861, 95900 and 95904 and issued total payment of $798.71. The requestor contends that additional reimbursement is due for CPT codes 99201, 95861, and 95904.

   Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

   To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

   The 2010 DWC conversion factor for this service is 54.32.

The Medicare Conversion Factor is 36.0791

Review of Box 32 on the CMS-1500 the services were rendered in Houston, Texas; therefore, the Medicare participating amount is based upon the locality of “Houston, Texas”.

Code	Medicare Participating Amount	MAR	Amount Paid per EOB	Amount Due
99201	$39.49	$59.45	$56.41	$3.04
95861	$121.28	$182.60	$176.66	$5.94
95904 (X4)	$47.86/ea	$72.06 X 4 = $288.24	$63.13 X 4 = $252.52	$35.72

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $44.70.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $44.70 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	06/04/2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.